# STATE OF NEW MEXICO
# WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

## WORKER'S RESPONSE

Worker responds to Employer/Insurer's ☐ **Complaint** and/or ☐ **Application to Judge** *(check all that apply)*:

☐ I was hurt on the job.

☐ I am disabled.

☐ I have not returned to work.

☐ My doctor has not released me to return to work.

☐ Employer has not provided work within my restrictions.

☐ I gave notice of the accident to my employer within 15 days of the accident.

☐ Employer has not provided adequate medical care.

☐ The statute of limitations does not bar my entitlement to weekly benefits.

☐ A causal link between my disability and accident has been shown to a reasonable degree of medical probability.

☐ Other:

_____
Signature Date

_____
Print name

_____
Address

_____
City/State/Zip

_____
Telephone

_____
E-mail address for service